Form 5500	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110		
Department of the Treasury	This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and	1210-0089		
Department of Labor	sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).	2011		
Employee Benefits Security Administration	Complete all entries in accordance with the instructions to the Form 5500.			
Pension Benefit Guaranty Corporation		This Form is Open to Public Inspection		
Part I Annual Report Ider	ntification Information			
For calendar plan year 2011 or fiscal		2012		
A This return/report is for:	a multiemployer plan; a multiple-employer plan; or			
	🗙 a single-employer plan;			
B This return/report is:	the first return/report; the final return/report;			
	an amended return/report;	than 12 months).		
\mathbf{C} If the plan is a collectively-bargain	ed plan, check here.			
D Check box if filing under:	▼ Form 5558; □ automatic extension;	the DFVC program;		
	\square special extension (enter description)			
Part II Basic Plan Inform	nation—enter all requested information			
1a Name of plan		1b Three-digit plan 501		
SAVER GROUP, INC. WELFARE BE	NEFIT PROGRAM	number (PN) >		
		1c Effective date of plan 03/01/1992		
2a Plan sponsor's name and addres	s, including room or suite number (Employer, if for single-employer plan)	2b Employer Identification Number (EIN) 31-1532482		
		2c Sponsor's telephone number 270-465-8675		
95 LONDON DRIVE PO BOX 1058 CAMPBELLSVILLE, KY 42719	95 LONDON DRIVE PO BOX 1058 CAMPBELLSVILLE, KY 42719	2d Business code (see instructions) 445110		

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	12/17/2012	LARRY NOE
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
NEKE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
HERE	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Page 2

	Plan administrator's name and address (if same as plan sponsor, enter "Same") VER GROUP, INC.	3b Administrator's EIN 31-1532482		
PC	LONDON DRIVE) BOX 1058 MPBELLSVILLE, KY 42719	3c Administrator's telephone number 270-465-8675		
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN the plan number from the last return/report:	and	4b EIN	
а	Sponsor's name		4c PN	
5	Total number of participants at the beginning of the plan year	5	557	
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).			
а	Active participants	6a	639	
b	Retired or separated participants receiving benefits	6b		
С	Other retired or separated participants entitled to future benefits	6c		
d	Subtotal. Add lines 6a, 6b, and 6c	6d	639	
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e		
f	Total. Add lines 6d and 6e	6f	639	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g		
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h		
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7		
8a	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes	s in the	instructions:	

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions: 4A 4B 4D 4E 4F 4H

9a	a Plan funding arrangement (check all that apply)			9b Plan benefit arrangement (check all that apply)			
	(1)	X	Insurance		(1)	X	Insurance
	(2)		Code section 412(e)(3) insurance contracts		(2)		Code section 412(e)(3) insurance contracts
	(3)		Trust		(3)		Trust
	(4)		General assets of the sponsor		(4)		General assets of the sponsor
10	10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)						
a Pension Schedules			b General Schedules				
	(1)		R (Retirement Plan Information)		(1)		H (Financial Information)
	(2)		MB (Multiemployer Defined Benefit Plan and Certain Money		(2)	Π	I (Financial Information – Small Plan)
		_	Purchase Plan Actuarial Information) - signed by the plan		(3)	X	<u>7</u> A (Insurance Information)
			actuary		(4)	Х	C (Service Provider Information)
	(3)	Π	SB (Single-Employer Defined Benefit Plan Actuarial		(5)		D (DFE/Participating Plan Information)
			Information) - signed by the plan actuary		(6)		G (Financial Transaction Schedules)

SCHEDULE		Insuranc	ce Informatio	n		ON	/IB No. 1210-0110	
(Form 5500) Department of the Treasury Internal Revenue Service This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					2011			
	Department of Labor Employee Benefits Security Administration File as an attachment to Form 5500.							
Pension Benefit Guaranty C		 Insurance companies a pursuant to E 	re required to provide t RISA section 103(a)(2)		tion	This For	rm is Open to Public Inspection	
For calendar plan year 2011 or fiscal plan year beginning 03/01/2011 and ending 02/29/201					/29/2012			
A Name of plan SAVER GROUP, INC. W	ELFARE BENE	FIT PROGRAM			e-digit number (P	N) 🕨	501	
C Plan sponsor's name a SAVER GROUP, INC.	C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number 31-1532482 SAVER GROUP, INC. 31-1532482					ation Number	(EIN)	
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:								
(a) Name of insurance ca UNITED OF OMAHA LIF		COMPANY						
	(c) NAIC	(d) Contract or	(e) Approximate nu	umber of		Policy or c	ontract year	
(b) EIN	code	identification number	persons covered a policy or contrac			From	(g) To	
47-0322111	69868	GLUG0501G	620		03/01/2011		02/29/2012	
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	al commissions paid. L	ist in item 3	the agents	, brokers, and	other persons in	
(a) Total	amount of comn			(b) To	otal amount	of fees paid		
		5886						
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).				
		nd address of the agent, broker,	•	m commiss	ions or fees	were paid		
BB&T INSURANCE SER	VICES		OX 436869 SVILLE, KY 40253					
(b) Amount of sales a	nd base	Fee	s and other commission	ns paid				
commissions pa	1	(c) Amount		(d) Purpos	e		(e) Organization code	
5886							3	
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid		
	ndhaaa	Fee	s and other commission	ns paid				
(b) Amount of sales a commissions pa		(c) Amount	(d) Purpose			(e) Organization code		

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

(b) Amount of sales and base	I	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						

(b) Amount of sales and base	Fees and other commissions paid					
commissions paid	(c) Amount	(d) Purpose	(e) Organization code			

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

P	art I					
		Where individual contracts are provided, the entire group of such individual this report.	vidual contract	s with each carrier m	ay be treated a	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end			
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	end		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а		ate participatio	• /		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits				
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)	7c(5)			
		•				
					70(0)	
	A	(6)Total additions			7c(6) 7d	
		Total of balance and additions (add b and c(6)) Deductions:	·····		7u	
	C	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier				
		(3) Transferred to separate account	_ (-)			
		(4) Other (specify below)				
		·				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)				

a

	Schedule A (Form 5500) 2011		Pag	je 4	
art I	II Welfare Benefit Contract Informat If more than one contract covers the same guinformation may be combined for reporting p the entire group of such individual contracts	roup of employees of the sa urposes if such contracts ar	re experience	e-rated as a unit. Where contract	
Ber	efit and contract type (check all applicable boxes)				
а	Health (other than dental or vision)	b Dental	c	Vision	d X Life insurance
е	Temporary disability (accident and sickness)	f Long-term disability	g	Supplemental unemployment	h Prescription drug
i	Stop loss (large deductible)	j 🗌 HMO contract	k∏	PPO contract	I Indemnity contract
m	Other (specify) ►AD&D				
Exp	erience-rated contracts:				
а	Premiums: (1) Amount received		9a(1)		
	(2) Increase (decrease) in amount due but unpaid	d	9a(2)		
	(3) Increase (decrease) in unearned premium res	serve	9a(3)		
	(4) Earned ((1) + (2) - (3))				
b	Benefit charges (1) Claims paid		9b(1)	30000	0
	(2) Increase (decrease) in claim reserves		9b(2)		
	(3) Incurred claims (add (1) and (2))				30000
	(4) Claims charged				
С	Remainder of premium: (1) Retention charges (c	on an accrual basis)			
	(A) Commissions		9c(1)(A)		
	(B) Administrative service or other fees		9c(1)(B)		
	(C) Other specific acquisition costs		9c(1)(C)		

10 Nonexperience-rated contracts:

е

10a а Total premiums or subscription charges paid to carrier 32316 b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

9c(1)(D)

9c(1)(E)

9c(1)(F)

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10b retention of the contract or policy, other than reported in Part I, item 2 above, report amount..... Specify nature of costs

(H) Total retention (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)

(D) Other expenses

(E) Taxes..... (F) Charges for risks or other contingencies

Part IV	Provision of Information			
11 Did	he insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12 If th	answer to line 11 is "Yes," specify the information not provided.			

						r		
SCHEDULE		Insuran	ce Information	n		ON	/B No. 1210-0110	
(Form 5500 Department of the Treas	,	This schedule is required	to be filed under section	on 104 of th	e	·		
Internal Revenue Serv	rice	Employee Retirement Inc					2011	
Department of Labo Employee Benefits Security Ad	ministration	File as an attachment to Form 5500.						
Pension Benefit Guaranty Co	orporation	 Insurance companies a pursuant to E 	are required to provide t RISA section 103(a)(2)		ion	This For	Form is Open to Public Inspection	
For calendar plan year 20	11 or fiscal plar	year beginning 03/01/2011		and en	ding 02	/29/2012		
A Name of plan SAVER GROUP, INC. W	ELFARE BENE	FIT PROGRAM			e-digit number (Pl	N) 🕨	501	
		20 of Form FEOD			vor Idontific	otion Number		
C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number (31-1532482				(EIN)				
		ing Insurance Contract (Individual contracts grouped as a						
1 Coverage Information:								
(a) Name of insurance ca		ANTHEM BLUE CROSS AND BI	LUE SHIELD					
	())) ()	(1) 0	(e) Approximate nu	umber of		Policy or c	ontract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contrac	t end of	(f)	From	(g) To	
61-1237516 95120		00092132	765		03/01/20)11	02/29/2012	
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	al commissions paid. L	ist in item 3	the agents	, brokers, and	other persons in	
(a) Total :	amount of comr	nissions paid		(b) To	otal amount	of fees paid		
		29905						
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).				
		nd address of the agent, broker,	•	m commiss	ions or fees	were paid		
BB&T INSURANCE SER	VICES		OX 436869 SVILLE, KY 40253					
(b) Amount of sales a	nd base	Fee	s and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose			(e) Organization code	
29905							3	
	(a) Namo a	nd address of the agent, broker,	or other person to when	m commiss	ions or foos	woro paid		
	(d) Name a	nu address of the agent, broker,	or other person to who			were paid		
(b) Amount of sales a	nd base	Fee	s and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code	

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2011 v.012611

(b) Amount of sales and base	I	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					

(b) Amount of sales and base commissions paid		(e) Organization	
	(c) Amount	(d) Purpose	code

(b) Amount of sales and base commissions paid		(e) Organization	
	(c) Amount	(d) Purpose	code

P	art I					
		Where individual contracts are provided, the entire group of such individual this report.	vidual contract	s with each carrier m	ay be treated a	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end			
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	end		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а		ate participatio	• /		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits				
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)	7c(5)			
		•				
					70(0)	
	А	(6)Total additions			7c(6) 7d	
		Total of balance and additions (add b and c(6)) Deductions:	·····		7u	
	C	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier				
		(3) Transferred to separate account	_ (-)			
		(4) Other (specify below)				
		·				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)				

Page 4

Part II	Welfare Benefit Contract Information If more than one contract covers the same guinformation may be combined for reporting p the entire group of such individual contracts	roup of employees of the surposes if such contracts	are experiend	ce-rated as a unit. Where cont	
8 Bene	efit and contract type (check all applicable boxes)				
a 🕽	Health (other than dental or vision)	b Dental	c	Vision	d Life insurance
e	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unemploymen	t h Prescription drug
i	Stop loss (large deductible)	i HMO contract	k		I Indemnity contract
m	Other (specify)	, []	L]	
[
9 Expe	rience-rated contracts:				
a F	Premiums: (1) Amount received		9a(1)	1961:	320
	(2) Increase (decrease) in amount due but unpaid	d	9a(2)		
	(3) Increase (decrease) in unearned premium res	serve	9a(3)		
	(4) Earned ((1) + (2) - (3))				<i>'</i>
b	Benefit charges (1) Claims paid			15013	317
	(2) Increase (decrease) in claim reserves				
	(3) Incurred claims (add (1) and (2))				
	(4) Claims charged				4)
С	Remainder of premium: (1) Retention charges (c				
	(A) Commissions		9c(1)(A)		905
	(B) Administrative service or other fees		9c(1)(B)	236	205
	(C) Other specific acquisition costs		9c(1)(C)		
	(D) Other expenses		9c(1)(D) 9c(1)(E)		
	(E) Taxes				
	(F) Charges for risks or other contingencies.(G) Other retention charges				
	(H) Total retention				(H) 266110
	(2) Dividends or retroactive rate refunds. (These	—	_		
Ь	Status of policyholder reserves at end of year: (1				
d	(2) Claim reserves	, ,			/
е	(3) Other reserves Dividends or retroactive rate refunds due. (Do n				
	nexperience-rated contracts:		∡ ⊪ • •(∠ <i>j</i> .)		-
	Total premiums or subscription charges paid to o	carrier			a
	If the carrier, service, or other organization incur				a
~	retention of the contract or policy, other than rep	, ,			b

Specify nature of costs 🕨

Part IV	Provision of Information			
11 Did the in	surance company fail to provide any information necessary to complete Schedule A?	Yes	× No	
12 If the ans	wer to line 11 is "Yes," specify the information not provided.			

	I					1	
SCHEDULE	A	Insurance	ce Information	n		ON	/B No. 1210-0110
(Form 5500		This ask shuls is assuing t	l ta ha filad wadan aa tia		_		
Department of the Trea Internal Revenue Serv	sury /ice	This schedule is required Employee Retirement Inc					2011
Department of Labo Employee Benefits Security Ac		File as an attachment to Form 5500.					
Pension Benefit Guaranty Co	orporation	 Insurance companies a pursuant to E 	re required to provide t RISA section 103(a)(2)		ion	This Fo	rm is Open to Public Inspection
For calendar plan year 2011 or fiscal plan year beginning03/01/2011and ending02/29/2012							
A Name of plan SAVER GROUP, INC. W	ELFARE BENE	FIT PROGRAM			e-digit number (Pl	N) 🕨	501
C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number (31-1532482) SAVER GROUP, INC. 31-1532482				(EIN)			
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:		individual contracto grouped as t					
(a) Name of insurance ca THE GUARDIANLIFE IN:		IPANY OF AMERICA					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year
(b) EIN (c) NAIC code		identification number	persons covered a policy or contrac		(f)	From	(g) To
13-5123390 64246 00422505		25	54	03/01/20)11	02/29/2012	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in item 3	the agents	, brokers, and	other persons in
(a) Total	amount of comm			(b) To	otal amount	of fees paid	
		9163					4478
3 Persons receiving com		ees. (Complete as many entries					
BB&T INSURANCE SER		nd address of the agent, broker,	or other person to who OX 7266	m commiss	ions or fees	were paid	
DD&T INSURANCE SER	VICES INC.		NVILLE, NC 27835				
(b) Amount of sales a	nd base	Fee	s and other commission	ns paid			_
commissions pa		(c) Amount		(d) Purpos	Э		(e) Organization code
9163		4478					3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
	nd booo	Fee	s and other commission	ns paid			
(b) Amount of sales a commissions pa		(c) Amount	(d) Purpose				(e) Organization code

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

(b) Amount of sales and base	I	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					

(b) Amount of sales and base commissions paid		(e) Organization	
	(c) Amount	(d) Purpose	code

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

P	art I					
		Where individual contracts are provided, the entire group of such individual this report.	vidual contract	s with each carrier m	ay be treated a	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end			
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	end		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а		ate participatio	• /		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits				
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)	7c(5)			
		•				
					70(0)	
	А	(6)Total additions			7c(6) 7d	
		Total of balance and additions (add b and c(6)) Deductions:	·····		7u	
	C	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier				
		(3) Transferred to separate account	_ (-)			
		(4) Other (specify below)				
		·				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)				

Page 4

Part III Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the urposes if such contracts	are experien	ce-rated as a unit. Wh	nere contracts	loyee organizations(s), the s cover individual employees,
8 Benefit and contract type (check all applicable boxes)					
a Health (other than dental or vision)	b X Dental	с	Vision	(d 🗌 Life insurance
e Temporary disability (accident and sickness)	f Long-term disabili	itv a	Supplemental unem	plovment	h Prescription drug
i Stop loss (large deductible)	i HMO contract	· · ·	PPO contract		I Indemnity contract
		ĸ			
m _ Other (specify) ►					
9 Experience-rated contracts:					
a Premiums: (1) Amount received		. 9a(1)			4
(2) Increase (decrease) in amount due but unpai					1
(3) Increase (decrease) in unearned premium re-					1
(4) Earned ((1) + (2) - (3))				. 9a(4)	
b Benefit charges (1) Claims paid		. 9b(1)			
(2) Increase (decrease) in claim reserves		. 9b(2)			
(3) Incurred claims (add (1) and (2))				. 9b(3)	
(4) Claims charged				. 9b(4)	
C Remainder of premium: (1) Retention charges (on an accrual basis)				
(A) Commissions		9c(1)(A)			
(B) Administrative service or other fees					1
(C) Other specific acquisition costs					4
(D) Other expenses		9c(1)(D)			-
(E) Taxes					4
(F) Charges for risks or other contingencies					
(G) Other retention charges				00/(1)/(1)	
(H) Total retention	_	_		. 9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These				\ /	-
d Status of policyholder reserves at end of year: (*					
(2) Claim reserves				. 9d(2)	
(3) Other reserves				. 9d(3)	
e Dividends or retroactive rate refunds due. (Do r 10 Nonexperience-rated contracts:	iot include amount entered	u iii ⊌(∠) .)		. 9e	
a Total premiums or subscription charges paid to	carrier			. 10a	91632
b If the carrier, service, or other organization incur					91032
retention of the contract or policy, other than rep				. 10b	

Specify nature of costs

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	Х	No
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	^	Incuranc	o Informatio	n			
					OM	B No. 1210-0110	
(Form 5500) Department of the Treasu		This schedule is required to be filed under section 104 of the			е		
Internal Revenue Servic	e	Employee Retirement Inc	ome Security Act of 19	974 (ERISA).		2011
Employee Benefits Security Adm		File as an at	tachment to Form 55	00.			
Pension Benefit Guaranty Corp	poration	 Insurance companies ar pursuant to Ef 	e required to provide t RISA section 103(a)(2)		ion		m is Open to Public Inspection
For calendar plan year 201	1 or fiscal plan	year beginning 03/01/2011		and en	0	/29/2012	
A Name of plan SAVER GROUP, INC. WE	LFARE BENE	FIT PROGRAM			e-digit number (Pl	N) 🕨	501
C Plan sponsor's name as SAVER GROUP, INC.	s shown on line	e 2a of Form 5500		D Emplo 31-153	-	ation Number (EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance carr UNITED OF OMAHA LIFE		COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu	umber of		Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
47-0322111	69868	GVTL0501G	19	99	03/01/20)11	02/29/2012
2 Insurance fee and comm descending order of the		ation. Enter the total fees and tota	l commissions paid. L	ist in item 3	the agents	, brokers, and c	other persons in
	mount of comn	nissions paid		(b) To	tal amount	of fees paid	
		9203					
3 Persons receiving comm	nissions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
BB&T INSURANCE SERV	. /	nd address of the agent, broker, o	or other person to who X 436869	m commiss	ions or fees	were paid	
DD&T INSURANCE SERV	ICES		VILLE, KY 40253				
		Fees	s and other commission	ns paid			
(b) Amount of sales and commissions paid		(c) Amount	(d) Purpose				(e) Organization code
	8594						3
	(a) Name a	nd address of the agent, broker, c	or other person to who	m commiss	ions or fees	were paid	1
NEACE & ASSOCIATES, I	INC.		RIVER ROAD VILLE, KY 40206				
(b) Amount of sales and	d base	Fees	s and other commission	ns paid			
commissions paid		(c) Amount		(d) Purpos	9		(e) Organization code
	609						3
For Paperwork Reduction	Act Notice a	nd OMB Control Numbers, see	the instructions for F	orm 5500.		Scheo	ule A (Form 5500) 2011 v.012611

(b) Amount of sales and base commissions paid	I	(e) Organization						
	(c) Amount	(d) Purpose	code					
(a) Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid		(e) Organization						
	(c) Amount	(d) Purpose	code					
(a) Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

P	art I					
		Where individual contracts are provided, the entire group of such individual this report.	vidual contract	s with each carrier m	ay be treated a	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end			
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	end		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а		ate participatio	• /		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits				
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)	7c(5)			
		•				
					70(0)	
	А	(6)Total additions			7c(6) 7d	
		Total of balance and additions (add b and c(6)) Deductions:	·····		7u	
	C	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier				
		(3) Transferred to separate account	_ (-)			
		(4) Other (specify below)				
		·				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)				

9

		Schedule A (Form 5500) 2011		Pa	age 4		
Pa	art III	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pr the entire group of such individual contracts	oup of employees of the sai	e experienc	ce-rated as a unit. Wi	here contract	
8	Benefi	t and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	b Dental	c	Vision		d X Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	g	Supplemental uner	nployment	h Prescription drug
	i 🗍	Stop loss (large deductible)	j 🗍 HMO contract	k	PPO contract		I Indemnity contract
	m×	Other (specify) AD&D			-		—
9	Experi	ence-rated contracts:					_
	a Pr	emiums: (1) Amount received		9a(1)			_
	(2) Increase (decrease) in amount due but unpaid	L	9a(2)			_
	(3) Increase (decrease) in unearned premium res	serve	9a(3)	L		
	(4	Earned ((1) + (2) - (3))				9a(4)	
	b B	enefit charges (1) Claims paid		9b(1)		50000	_
	(2) Increase (decrease) in claim reserves		9b(2)	L		
	(3) Incurred claims (add (1) and (2))				9b(3)	50000
	(4) Claims charged				9b(4)	
	CR	emainder of premium: (1) Retention charges (o	n an accrual basis)				_
		(A) Commissions		9c(1)(A)			_
		(B) Administrative service or other fees		9c(1)(B)			_
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			

	(F) Charges for risks or other contingencies	9c(1)(F)				
	(G) Other retention charges	9c(1)(G)				
	(H) Total retention			9c(1)(H)		
	(2) Dividends or retroactive rate refunds. (These amounts were paid in	n cash, or	credited.)	9c(2)		
d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits afte	r retirement	9d(1)		
	(2) Claim reserves			9d(2)		
	(3) Other reserves			9d(3)		
е	Dividends or retroactive rate refunds due. (Do not include amount entered	d in c(2) .)		9e		
10 No	onexperience-rated contracts:		_			
а	Total premiums or subscription charges paid to carrier			10a	535	571
b	If the carrier, service, or other organization incurred any specific costs in c retention of the contract or policy, other than reported in Part I, item 2 abo			10b		

Specify nature of costs

Part IV Provision of Information			
11 Did the insurance company fail to provide any information necessary to complete Schedule A?	Yes	× No	
12 If the answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insuranc	e Informatio	n				
(Form 5500		mourune		•		OM	B No. 1210-0110	
Department of the Treas Internal Revenue Serv	sury	This schedule is required Employee Retirement Inc					2011	
Department of Labor Employee Benefits Security Ad			tachment to Form 55	·	,-			
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).					m is Open to Public Inspection			
For calendar plan year 20	11 or fiscal plan	year beginning 03/01/2011		and en	ding 02	/29/2012		
A Name of plan SAVER GROUP, INC. WI	ELFARE BENE	FIT PROGRAM			e-digit number (Pl	N) 🕨	501	
				_				
C Plan sponsor's name a SAVER GROUP, INC.	C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification No. 31-1532482					ation Number (EIN)	
		ing Insurance Contract C Individual contracts grouped as a						
1 Coverage Information:		· ·				-		
(a) Name of insurance ca UNITED OF OMAHA LIFE		COMPANY						
	() 1400	()) () () ()	(e) Approximate nu	umber of		Policy or co	ontract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contrac		(f)	From	(g) To	
47-0322111	69868	GUC0501G	19	98	03/01/20)11	02/29/2012	
2 Insurance fee and com descending order of the		tion. Enter the total fees and total	l commissions paid. L	ist in item 3	the agents	, brokers, and c	other persons in	
	amount of comn			(b) To	otal amount	of fees paid		
		8271						
3 Persons receiving com		es. (Complete as many entries a	•	, ,				
		nd address of the agent, broker, o	or other person to who X 436869	m commiss	ions or fees	were paid		
BB&T INSURANCE SER	VICES INC.		VILLE, KY 40253					
(b) Amount of sales ar	nd base	Fees	and other commission	ns paid				
commissions pai		(c) Amount	(d) Purpose			(e) Organization code		
	7721						3	
	(a) Name a	nd address of the agent, broker, c	or other person to who	m commiss	ions or fees	were paid	1	
NEACE & ASSOCIATES		2305 R	RIVER ROAD VILLE, KY 40206					
		Fees	and other commission	ns paid				
(b) Amount of sales and base commissions paid (c) Amount				(d) Purpos	Э		(e) Organization code	
	550						3	
For Paperwork Reduction	n Act Notice a	nd OMB Control Numbers, see	the instructions for F	orm 5500		Scher	dule A (Form 5500) 2011	
						001100	v.012611	

(b) Amount of sales and base	I	(e) Organization			
commissions paid	(c) Amount (d) Purpose		code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

P	art I					
		Where individual contracts are provided, the entire group of such individual this report.	vidual contract	s with each carrier m	ay be treated a	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end			
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	end		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а		ate participatio	• /		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits				
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)	7c(5)			
		•				
					70(0)	
	А	(6)Total additions			7c(6) 7d	
		Total of balance and additions (add b and c(6)) Deductions:	·····		7u	
	C	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier				
		(3) Transferred to separate account	_ (-)			
		(4) Other (specify below)				
		·				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)				

Page	4

Pa	art II						
		If more than one contract covers the same gr information may be combined for reporting pr the entire group of such individual contracts	urposes if such contracts a	are experienc	ce-rated as a unit. Wh	ere contracts	
8	Bene	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance
	e 🛛	Temporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unem	plovment	h Prescription drug
	ιΓ	Stop loss (large deductible)	j HMO contract		PPO contract		I Indemnity contract
	- L			n_			
	m	Other (specify)					
9	Expe	rience-rated contracts:					
	•	Premiums: (1) Amount received		9a(1)			1
		(2) Increase (decrease) in amount due but unpaid	J				
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)		47204	
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	47204
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (or	n an accrual basis)]
		(A) Commissions		9c(1)(A)]
		(B) Administrative service or other fees		9c(1)(B)]
		(C) Other specific acquisition costs		9c(1)(C)			1
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies.					
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention	—			9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide I	benefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	l in c(2) .)		. 9e	
10		nexperience-rated contracts:				r	
	-	Total premiums or subscription charges paid to c				10a	4895
		If the carrier, service, or other organization incurr				401	
		retention of the contract or policy, other than repe	orted in Part I, item 2 abov	/e, report am	ount	. 10b	

Specify nature of costs 🕨

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X	No
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	HEDULE A Insurance Information						
(Form 5500					-	OM	B No. 1210-0110
Department of the Treas Internal Revenue Servi	sury	This schedule is required Employee Retirement Inc				2011	
	Department of Labor File as an attachment to Form 5500.						
 Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). 					m is Open to Public Inspection		
For calendar plan year 207	11 or fiscal plan	year beginning 03/01/2011		and er	ding 02/2	29/2012	•
A Name of plan SAVER GROUP, INC. WI	ELFARE BENEI	FIT PROGRAM			e-digit number (PN)	501
C Plan sponsor's name a SAVER GROUP, INC.			-	31-153	32482	ation Number (
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca UNITED OF OMAHA LIFE		COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
47-0322111	69868	GUPR0501G	15	156 03/01/2011		02/29/2012	
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	l commissions paid. L	ist in item 3	the agents,	brokers, and c	other persons in
	amount of comn			(b) To	otal amount o	f fees paid	
		8041					
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all	persons).			
BB&T INSURANCE SER		nd address of the agent, broker, o	or other person to who X 436869	m commiss	ions or fees v	were paid	
DD&T INSURANCE SER	VICES INC.		VILLE, KY 40253				
(b) Amount of sales ar	nd base	Fees	s and other commission	ns paid			-
commissions pai		(c) Amount	(d) Purpose			(e) Organization code	
	7490						3
		nd address of the agent, broker, o	or other person to who	m commiss	ions or foos	were naid	
NEACE & ASSOCIATES		2305 F	RIVER ROAD VILLE, KY 40206				
(b) Amount of sales ar	nd base	Fees	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code
	551						3
For Paperwork Reductio	n Act Notice a	nd OMB Control Numbers, see	the instructions for F	Form 5500.		Schee	dule A (Form 5500) 2011 v.012611

(b) Amount of sales and base	I	(e) Organization			
commissions paid	(c) Amount (d) Purpose		code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Pa	art I					
		Where individual contracts are provided, the entire group of such individual this report.	vidual contract	s with each carrier m	ay be treated a	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end			
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	end		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а		ate participatio	• /		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits				
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)	7c(5)			
		•				
					70(0)	
	А	(6)Total additions			7c(6) 7d	
		Total of balance and additions (add b and c(6)) Deductions:	·····		7u	
	C	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier				
		(3) Transferred to separate account	_ (-)			
		(4) Other (specify below)				
		·				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)				

Page 4	•
--------	---

Pa	art II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr information may be combined for reporting pr the entire group of such individual contracts	urposes if such contracts	are experienc	ce-rated as a unit. Whe	ere contract	
8	Bene	efit and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance
	еΓ	Temporary disability (accident and sickness)	f 🛛 Long-term disabili	ty g	Supplemental unemp	olovment	h Prescription drug
	: [Stop loss (large deductible)	i HMO contract	∘, s_ k	PPO contract	Joginoni	I Indemnity contract
	' _			r _	PPO contract		
	m	Other (specify)					
9	Evne	rience-rated contracts:					
Ŭ	•	Premiums: (1) Amount received		9a(1)			-
		(2) Increase (decrease) in amount due but unpaid					-
		(3) Increase (decrease) in unearned premium res					
		(4) Earned ((1) + (2) - (3))				9a(4)	
	-	Benefit charges (1) Claims paid				21940	
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	21940
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (or	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs					
		(D) Other expenses		9c(1)(D)			
		(E) Taxes					
		(F) Charges for risks or other contingencies.					
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention	—	_		9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1	, 1				
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
		Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in c(2) .)		9e	
1(nexperience-rated contracts:					
	-	Total premiums or subscription charges paid to o				10a	48302
		If the carrier, service, or other organization incur retention of the contract or policy, other than repo				10b	
		recention of the contract of policy, other than rep	JICC III I AILI, ICIII Z ADU	ve, report and	ount	100	

Specify nature of costs 🕨

Part IV Provision of Information

11	Did the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X	No
12	If the answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE		Insuranc	ce Information	n		ON	1B No. 1210-0110	
(Form 5500 Department of the Treat	(Form 5500) Department of the Treasury This schedule is required to be filed under section 104 of the							
Internal Revenue Serv	rice	Employee Retirement Income Security Act of 1974 (ERISA).					2011	
Department of Labo Employee Benefits Security Ad	ministration	File as an a	ttachment to Form 55	00.				
Pension Benefit Guaranty Co	orporation	 Insurance companies a pursuant to E 	re required to provide t RISA section 103(a)(2)		ion	This For	This Form is Open to Public Inspection	
For calendar plan year 20	11 or fiscal plan	year beginning 03/01/2011		and en	ding 02	/29/2012		
A Name of plan SAVER GROUP, INC. W	FIT PROGRAM			e-digit number (Pl	N) 🕨	501		
C Dian anonanzia name de chaure en line 26 of Earre 5500								
C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number (EIN) SAVER GROUP, INC. 31-1532482								
		ing Insurance Contract C Individual contracts grouped as a						
1 Coverage Information:								
(a) Name of insurance ca	rrier							
		ANTHEM BLUE CROSS AND BL	LUE SHIELD					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year	
				From	(g) To			
61-1237516 95120 00013898 425 03/01/2011					02/29/2012			
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in item 3	the agents	, brokers, and o	other persons in	
(a) Total :	amount of comr			(b) To	otal amount	of fees paid		
		2549						
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).				
		nd address of the agent, broker,		m commiss	ions or fees	were paid		
BB&T INSURANCE SER	VICES INC.		DX 436869 SVILLE, KY 40253					
(b) Amount of sales a	nd base	Fee	s and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose			(e) Organization code	
	2549						3	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					-			
	(a) Name a	a address of the agent, broker,			10113 01 1663			
(b) Amount of sales a	ad base	Fee	s and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code	

For Domenticula Deduction Act Mation	and OMD Control Numbers	and the instructions for Form FF00
For Paperwork Reduction Act Notice	and OMB Control Numbers.	see the instructions for Form 5500.

Schedule A (Form 5500) 2011 v.012611

(b) Amount of sales and base	I	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base		(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

(b) Amount of sales and base		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code	

Pa	art I					
		Where individual contracts are provided, the entire group of such individual this report.	vidual contract	s with each carrier m	ay be treated a	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year				
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	end		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а		ate participatio	• /		
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits				
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)	7c(5)			
		•				
					70(0)	
	А	(6)Total additions			7c(6) 7d	
		Total of balance and additions (add b and c(6)) Deductions:	·····		7u	
	C	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier				
		(3) Transferred to separate account	_ (-)			
		(4) Other (specify below)				
		·				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)				

Page	4
------	---

Pa	art II							
		If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.						
8	Bene	efit and contract type (check all applicable boxes)	······, ····, ····					
-	a	Health (other than dental or vision)	b Dental	с×	Vision		d Life insurance	
	e	Temporary disability (accident and sickness)	f Long-term disabilit		1		h Prescription drug	
						Joyment		
	ין	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Expe	rience-rated contracts:						
-	•	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid						
		(3) Increase (decrease) in unearned premium res						
		(4) Earned ((1) + (2) - (3))				9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)	I				
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)			4	
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies					4	
		(G) Other retention charges	-			0=(1)(1)		
		(H) Total retention	_	_		9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These						
	d	Status of policyholder reserves at end of year: (1	•					
		(2) Claim reserves				9d(2)		
	•	(3) Other reserves				9d(3)		
10		Dividends or retroactive rate refunds due. (Do no	or include amount entered	a in C(∠) .)		9e		
10		nexperience-rated contracts:	orrior			100	0404	
	-	Total premiums or subscription charges paid to c If the carrier, service, or other organization incurr				10a	2464	
	U	retention of the contract or policy, other than repo				10b		

Specify nature of costs 🕨

Part IV	Provision of Information		
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	× No
12 If the	answer to line 11 is "Yes," specify the information not provided.		

SCHEDULE C	Service Provider Information		OMB No. 1210-0110	
(Form 5500)			2011	
Department of the Treasury Internal Revenue Service	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).		2011	
Department of Labor Employee Benefits Security Administration	File as an attachmen	nt to Form 5500.	This Form is Open to Public Inspection.	
Pension Benefit Guaranty Corporation For calendar plan year 2011 or fiscal pl	an vear beginning 03/01/2011	and ending 02/29	/2012	
A Name of plan SAVER GROUP, INC. WELFARE BEN	, , , , , , , , , , , , , , , , , , , ,	B Three-digit plan number (PN)	501	
C Plan sponsor's name as shown on I SAVER GROUP, INC.	ne 2a of Form 5500	D Employer Identification 31-1532482	on Number (EIN)	
Part I Service Provider Infe	ormation (see instructions)			
or more in total compensation (i.e., r plan during the plan year. If a perso	ordance with the instructions, to report the info noney or anything else of monetary value) in n received only eligible indirect compensatio include that person when completing the rem	connection with services rendered to n for which the plan received the requ	the plan or the person's position with the	
1 Information on Persons Re	ceiving Only Eligible Indirect Con	npensation		
a Check "Yes" or "No" to indicate whet indirect compensation for which theb If you answered line 1a "Yes," enter	her you are excluding a person from the remain olan received the required disclosures (see in r the name and EIN or address of each person	ainder of this Part because they receinstructions for definitions and condition providing the required disclosures	ns)XYes No	
 a Check "Yes" or "No" to indicate whet indirect compensation for which the b If you answered line 1a "Yes," entereceived only eligible indirect compensation 	her you are excluding a person from the remain olan received the required disclosures (see in r the name and EIN or address of each person nsation. Complete as many entries as needed	ainder of this Part because they receinstructions for definitions and condition providing the required disclosures ted (see instructions).	ns) Yes No	
 a Check "Yes" or "No" to indicate whet indirect compensation for which the b b If you answered line 1a "Yes," entereceived only eligible indirect compensation 	her you are excluding a person from the remain olan received the required disclosures (see in r the name and EIN or address of each person insation. Complete as many entries as needed arme and EIN or address of person who provid ICKY 3350 PEACHTREE PO BOX 30302-445	ainder of this Part because they receinstructions for definitions and condition providing the required disclosures feed (see instructions).	ns) Yes No	
 a Check "Yes" or "No" to indicate whet indirect compensation for which the b b If you answered line 1a "Yes," entereceived only eligible indirect competition (b) Enter na 	her you are excluding a person from the remain olan received the required disclosures (see in r the name and EIN or address of each person insation. Complete as many entries as needed arme and EIN or address of person who provided ICKY 3350 PEACHTREE	ainder of this Part because they receinstructions for definitions and condition providing the required disclosures feed (see instructions).	ns) Yes No	
 a Check "Yes" or "No" to indicate whet indirect compensation for which the point of the point of	her you are excluding a person from the remain olan received the required disclosures (see in r the name and EIN or address of each person insation. Complete as many entries as needed arme and EIN or address of person who provid ICKY 3350 PEACHTREE PO BOX 30302-445	ainder of this Part because they receinstructions for definitions and condition on providing the required disclosures feed (see instructions). ded you disclosures on eligible indirect ROAD	ns) Yes No	
 a Check "Yes" or "No" to indicate whet indirect compensation for which the point of the point of	her you are excluding a person from the remain olan received the required disclosures (see in r the name and EIN or address of each person mation. Complete as many entries as needed arme and EIN or address of person who provided ICKY 3350 PEACHTREE PO BOX 30302-445 ATLANTA, GA 3032	ainder of this Part because they receinstructions for definitions and condition on providing the required disclosures feed (see instructions). ded you disclosures on eligible indirect ROAD	ns) Yes No	
 a Check "Yes" or "No" to indicate whet indirect compensation for which the point of the point of	her you are excluding a person from the remain olan received the required disclosures (see in r the name and EIN or address of each person mation. Complete as many entries as needed arme and EIN or address of person who provided ICKY 3350 PEACHTREE PO BOX 30302-445 ATLANTA, GA 3032	ainder of this Part because they receinstructions for definitions and condition on providing the required disclosures feed (see instructions). ded you disclosures on eligible indirect ROAD	ns) Yes No	
 a Check "Yes" or "No" to indicate whet indirect compensation for which the point of the point of	her you are excluding a person from the remain olan received the required disclosures (see in r the name and EIN or address of each person mation. Complete as many entries as needed arme and EIN or address of person who provided ICKY 3350 PEACHTREE PO BOX 30302-445 ATLANTA, GA 3032	ainder of this Part because they receinstructions for definitions and condition on providing the required disclosures feed (see instructions). ded you disclosures on eligible indirect ROAD	ns) Yes No	
 a Check "Yes" or "No" to indicate whet indirect compensation for which the indirect compensation for which the received only eligible indirect compe (b) Enter na ANTHEM HEALTH PLANS OF KENTU 61-1237516 	her you are excluding a person from the remain olan received the required disclosures (see in r the name and EIN or address of each person mation. Complete as many entries as needed arme and EIN or address of person who provided ICKY 3350 PEACHTREE PO BOX 30302-445 ATLANTA, GA 3032	ainder of this Part because they receinstructions for definitions and condition on providing the required disclosures the ed (see instructions). ded you disclosures on eligible indirect ROAD 26 ded you disclosure on eligible indirect	ns) Yes No for the service providers who ct compensation t compensation	
 a Check "Yes" or "No" to indicate whet indirect compensation for which the indirect compensation for which the received only eligible indirect compe (b) Enter na ANTHEM HEALTH PLANS OF KENTU 61-1237516 (b) Enter na (b) Enter	her you are excluding a person from the remain olan received the required disclosures (see in r the name and EIN or address of each person mation. Complete as many entries as needed arme and EIN or address of person who provide ICKY 3350 PEACHTREE PO BOX 30302-445 ATLANTA, GA 3032	ainder of this Part because they receinstructions for definitions and condition on providing the required disclosures the ed (see instructions). ded you disclosures on eligible indirect ROAD 26 ded you disclosure on eligible indirect	ns) Yes No for the service providers who ct compensation t compensation	
a Check "Yes" or "No" to indicate whet indirect compensation for which the b If you answered line 1a "Yes," ente received only eligible indirect compe (b) Enter na ANTHEM HEALTH PLANS OF KENTU 61-1237516 (b) Enter na (b) Enter na	her you are excluding a person from the remain olan received the required disclosures (see in r the name and EIN or address of each person mation. Complete as many entries as needed arme and EIN or address of person who provide ICKY 3350 PEACHTREE PO BOX 30302-445 ATLANTA, GA 3032	ainder of this Part because they receinstructions for definitions and condition on providing the required disclosures they ded (see instructions). ded you disclosures on eligible indirect ROAD 26 ded you disclosure on eligible indirect ded you disclosure on eligible indirect	Ins) Yes No for the service providers who ct compensation t compensation ct compensation	

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

Page 3 -	1
----------	---

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)						
(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes 🗌 No 🗌		Yes 🗌 No 🗌
		(a) Enter name and EIN or	address (see instructions)		
	_					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes 🗌 No 🗌		Yes 🗌 No 🗌
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes 🗌 No 🗌	Yes 🗌 No 🗌		Yes 🗌 No 🗌

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)						
(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes 🗌 No 🗌	Yes 🗌 No 🗌		Yes No
		(a) Enter name and EIN or	address (see instructions)		
					-	
(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes 🗌 No 🗌	Yes 🗌 No 🗌		Yes 🗌 No 🗌
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes 🗌 No 🗌	Yes 🗌 No 🗍		Yes 🗌 No 🗌

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation
		componidation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect c	ompensation, including any
	formula used to determine	the service provider's eligibility ne indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(C) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation		ompensation, including any the service provider's eligibility
		ne indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(C) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	ompensation, including any the service provider's eligibility
	for or the amount of the	ne indirect compensation.

Page **5-** 1

P	art II Sei	vice Providers Who Fail or Refuse to	Provide Infor	mation
4	Provide, to t this Schedu		ch service provide	r who failed or refused to provide the information necessary to complete
	(a) Enter na	me and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
	(a) Enter na	me and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
	(a) Enter na	me and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
	(a) Enter na	me and EIN or address of service provider (see instructions)	(b) Nature of Service	(C) Describe the information that the service provider failed or refused to provide
	(a) Enter na	me and EIN or address of service provider (see	(b) Nature of	(C) Describe the information that the service provider failed or refused to
		instructions)	Service Code(s)	provide
	(a) Enter na	me and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide

Part III		Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)		
а	Name		b EIN:	
С	Positic	n:		
d	Address:		e Telephone:	
Explanation:				

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:
-		

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation: